

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013602

STATE FILE NUMBER

FILED MAY 13 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

2063

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		d. STREET ADDRESS 5637 Oak Street	
Length of stay in 1b 10 yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Rosemary Walterbach			4. DATE OF DEATH Month Day Year April 24, 1959		
------------------------------------------------------------------------------------	--	--	------------------------------------------------------	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1948	9. AGE (In years last birthday) 10	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
------------------	---------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------	---------------------------------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------------	-------------------------------------

13a. FATHER'S NAME Ray Walterbach	13b. MOTHER'S MAIDEN NAME Bernadine Froeschl	14. NAME OF HUSBAND OR WIFE None
--------------------------------------	-------------------------------------------------	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Ray Walterbach, 5637 Oak St. K. C. Mo.
--------------------------------------------------------------------------------------------------------------------	---------------------------------	---------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchiopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Palsy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>491X</u>
-----------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
-----------------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------

21. I attended the deceased from Death occurred at	1955 to 4-24-59 and last saw her alive on 4-24-59	m on the date stated above; and to the best of my knowledge, from the causes stated.
-------------------------------------------------------	---------------------------------------------------	--------------------------------------------------------------------------------------

22a. SIGNATURE <u>Dr. C. Kealhofer</u>	(Degree or title) M.D.	22b. ADDRESS 6627 Pimlico St.	22c. DATE SIGNED 4-24-59
-------------------------------------------	---------------------------	----------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-27-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) Kansas City, Missouri
-----------------------------------------------------	----------------------	-----------------------------------------------------------	----------------------------------------------------------------

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar,	ADDRESS 20 W. Linwood K. C. Mo.	25. DATE RECD. BY LOCAL REG. 4-24-59	26. REGISTRAR'S SIGNATURE Silver Marshall
-------------------------------------------------	------------------------------------	-----------------------------------------	----------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Geo. C. Kealhofer

All diseases in Part I must be causally related.

2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Wm H Gentry
Licensed Embalmer No. 5038
P. O. Address R.C. MO.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.